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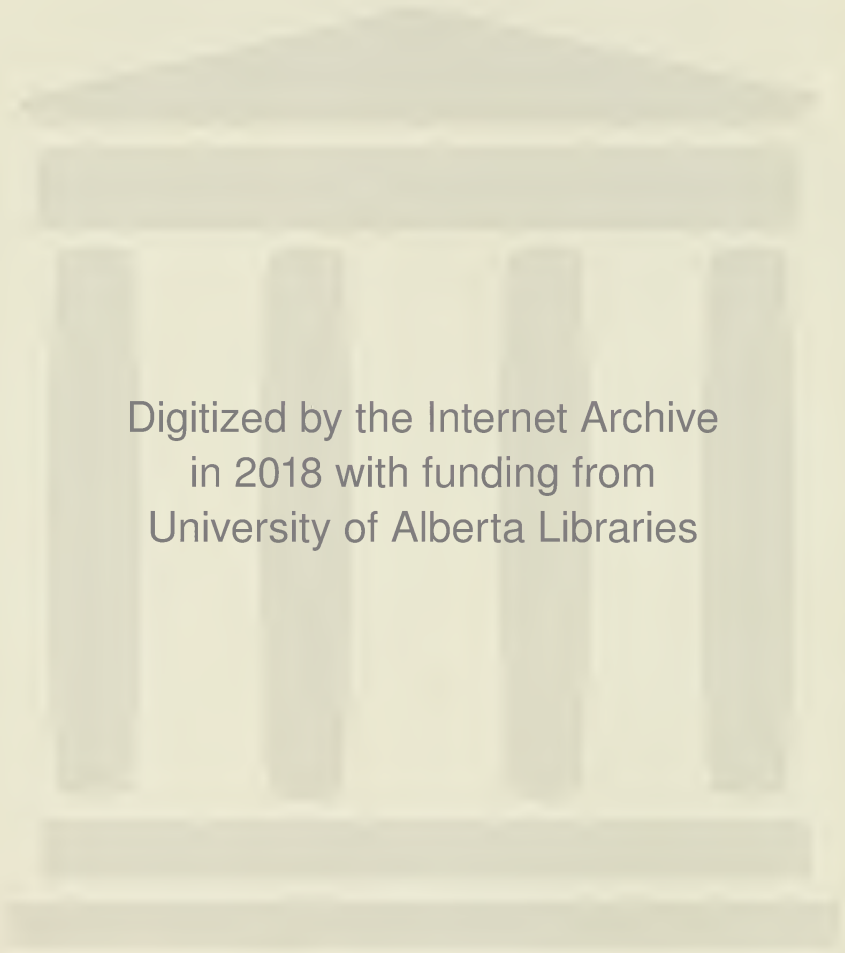

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THE UNIVERSITY OF ALBERTA

MENTAL HYGIENE CLINICS IN ALBERTA, WITH A STUDY OF SELECTED CLINIC CASES OF SCHOOL AGE

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

IN PARTIAL FULFILMENT OF THE DEGREE OF

BACHELOR OF EDUCATION

DEPARTMENT OF EDUCATION

BY

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EDMONTON, ALBERTA

MAY, 1937.

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CHAPTER I

MENTAL HYGIENE CLINICS IN ALBERTA

The Mental Hygiene Clinic Movement in Alberta is comparatively new. In order that the situation in regard to the Clinics may be clearly understood and Clinic set-up explained, a brief history of their establishment and life to date is given.

The Mental Hygiene, or Mental Health, Clinics in Alberta were started in the Fall of 1929 in three of the larger centers - namely, Edmonton, Calgary and Lethbridge. Later Clinics were established at Medicine Hat, Drumheller, and at the Provincial Mental Hospital, Ponoka. In the Fall of 1934, and again in the Fall of 1936, a series of Clinics was held throughout the Grande Prairie and Peace River country. It is planned to make this series of Clinics an annual affair, but the trip could not be made in 1935.

The Mental Hygiene Clinics, which are free, are an activity of the Provincial Health Department, and are entirely under its control. However, the attitude of those in charge has been one of co-operation, and the work has been co-ordinated with other Provincial and local activities, in so far as this seemed both possible and desirable. There is no doubt that greater co-ordination might be brought about in some instances, particularly if there was available a larger personnel for more joint and intensive work where this seemed called for.

The Clinic personnel consists of the physician in charge and the social worker. The physician, who is also a

psychiatrist in every case, interviews the patient referred, and relatives or guardians where this is possible, and does what examining seems indicated in the physical, neurological and psychiatric fields. The social worker assists in the interviews, and does any psychological and mental testing work required, and, in a certain number of cases, outside investigation work. When desired reports are sent out on the cases examined and recommendations made. In many cases efforts are made to have patients continue contact with the Clinics through return visits to facilitate observation of symptoms and progress in treatment. The maintaining of contacts would be much easier if more social workers were available. This would make the Clinic work more effective, also.

There are various agencies that refer cases to the Clinics, and, indeed, suitable cases may be referred by anyone. Quite a large number of cases are referred by and through the school authorities in the districts in which Clinics are established. Another group of cases comes through the children's organizations and juvenile courts, particularly through the Child Welfare workers, both Provincial and Civic. A third group is referred by the doctors. Other cases are referred by parents, relatives, friends, or through some other channel. (See Table VII)

The Clinics started under the able direction of Dr. Charles P. Fitzpatrick, who left the service of the Provincial Health Department in 1931. Co-operating with and assisting

Dr. Fitzpatrick were the then Minister of Health, Honorable George Hoadley, under whose authority the Clinics were set up, Dr. M. R. Bow, Deputy Minister of Health, Dr. J. M. MacEachran, in charge of the Department of Philosophy, University of Alberta, Dr. M. E. Lazerte, and Dr. H. E. Smith of the Department of Philosophy staff, Dr. E. H. Cooke, then Superintendent of the Provincial Mental Hospital, Dr. W. J. McAlister, then Superintendent of the Provincial Training School, and many others. Mr. S. K. Jaffary was the first social worker and psychologist.

In 1931 the active direction of the Clinics was taken over by the late Dr. C. A. Baragar, then Commissioner for Mental Institutions and Director of Mental Health for Alberta. Under Dr. Baragar's farsighted guidance and direction the clinic services continued to grow. Up to the time of his death, in March 1936, he took personal charge of many of the Clinics, and kept in close touch with the work carried on in the others. Since 1931, Dr. W. J. McAlister, now Superintendent of the Provincial Mental Institute, Edmonton, has been in charge of the major part of the work in the Edmonton Clinic, and is entirely in charge now. From 1931 to the end of 1935, Dr. George A. Davidson, then Superintendent of the Provincial Mental Hospital at Ponoka, took approximately half of the Clinics in the South of the Province, and did very able work. Dr. Davidson left the service of the Health Department at the end of 1935 and took up work in another Province. Since the

beginning of 1936 the major number of Clinics in the South of the Province have been taken by Dr. R. R. MacLean, Acting Medical Superintendent of the Provincial Mental Hospital, assisted by Dr. T. C. Michie, in charge of the Female Wards at the Provincial Mental Hospital, and by Dr. W. L. Valens, until recently in charge of the Provincial Auxiliary Hospital at Claresholm. Dr. Valens has now left the service to continue his studies along child guidance lines.

The social and psychological work was carried on till the Fall of 1931 by Mr. S. K. Jaffary. Following this Mr. E. J. Kibblewhite was on full time work in the South of the Province and at the Provincial Mental Hospital, with a part time social worker, Miss Agnes Starkie, in Edmonton. In the Spring of 1933 the position of part time social worker in Edmonton was discontinued. Since then Mr. Kibblewhite has had all of this work to do, and has attended nearly all of the Clinics held. This has meant that the amount of follow-up and outside work possible has been reduced to a minimum.

Another feature of the general programme of work has been that of the Eugenics Board. The Board was established in 1928, with the passing of the 'Sexual Sterilization Act', but the first cases were not considered till the Fall of 1929. Since then the Board has functioned steadily, meeting every two or three months for the consideration of cases. The Mental Health Clinics have proved invaluable in contacting cases outside of the Provincial Institutions, and in preparing them for presentation to the Board. To date the Board has passed over nine hundred and fifty cases, and of

these over four hundred and eighty have been operated on. (See Appendix A.)

The members of the Eugenics Board are Dr. J. M. MacEachran, Provost of the University of Alberta and head of the Department of Philosophy, Chairman; Dr. E. L. Pope, Director of Medical Services, University of Alberta Hospital; Dr. E. G. Mason, eminent neurologist of Calgary; and Mrs. Jean H. Field of Spurfield. The Board interviews every patient whose case is presented, and gives careful consideration to all the facts of the case before directing that the sterilization operation be carried out. The expenses of the operations are defrayed by the Province.

The following Tables may assist in giving a clearer idea of the work done through the Mental Hygiene Clinics. Tables I, II, and III show the number of clinics held at each of the clinic centers, the number of new cases dealt with, and indicate the amount of follow-up work done on cases that have been dealt with previously, for the years 1933, 1934, and 1935 respectively. Table IV shows the total number of new cases dealt with to December 31st., 1935. The years 1933, 1934 and 1935 have been chosen as being representative of the clinic work being carried on. The Edmonton Clinic is held every Monday afternoon in the Civic Block in the rooms used by the Baby Clinic. The Calgary Clinic is held every other Wednesday, as an all day clinic, in the Pre-School and Baby Clinic rooms in the City Hall. The Lethbridge Clinic is held every fourth Friday in the Nursing Mission. It is an all day clinic. The Medicine

Hat Clinic is held for two full days about every three months. The first day of each clinic visit is spent at the General Hospital where cases other than school cases are seen. The second day is spent in examining school cases. The Drumheller Clinic is held every two or three months and is a full day clinic. The trip through the Peace River and Grande Prairie district takes about two weeks, and is planned as an annual series of clinics. The clinics are held in the most suitable available quarters at the centers visited. The clinics have received support and able assistance from the Public Health Nurses wherever contacts have been made with them. This support and assistance has been particularly valuable in Calgary, Medicine Hat and Drumheller where they arrange the clinic appointments, and, when necessary, assist at the clinics. In many instances the nurse has made the initial contact with the patient which has resulted in a visit to the clinic for examination.

Tables V and VI show the distribution of the clinic cases according to age and sex for the years 1934 and 1935 respectively. A change in the method of setting up the table introduced in the 1934 compilation invalidates for comparative purposes the corresponding table for 1933 and it is not included. The tables that are given are largely self explanatory.

Tables VII and VIII show the sources from which cases are referred to the clinics. Table VII covers the clinic cases for 1934, and Table VIII covers those for 1935. Some facts of interest are brought out in these two tables. It

will be noted that few cases are referred directly from the schools in Edmonton, and few in Lethbridge, while there are a number referred in both Calgary and Medicine Hat. This is due in part at least to differences in school administration in the different centers, and in part to differences in clinic location and affiliations. More cases are referred by the Child Welfare in Edmonton than in any other center. This is mainly because Edmonton is the headquarters, and clearing center as it were, for Child Welfare work. The physicians refer a number of cases in each center. Relatives and friends refer an appreciable number of cases, and there seems a tendency for the number from this source to increase. Then there are quite a number of cases referred by various welfare institutions, and other agencies, as noted in the tables.

Tables IX and X, each given in three parts, A, B, and C, show the classification of cases according to age and problem. 'A' section of the tables covers the pre-school years, 'B' section the years from seven years to eighteen years, and 'C' section the years from nineteen years on. Table IX deals with the cases in 1934, and Table X deals with those in 1935. The different sub-headings given will explain the classification made in each section of the tables. It will be noted that of the four hundred and twenty-eight new cases examined in 1934, twenty, or 4.7%, were in the pre-school period, two hundred and seventy-nine, or 65.2%, were from seven to eighteen years of age, and one hundred and twenty-nine

or 30%, were nineteen years of age or over. Of the three hundred and sixty-three new cases examined in 1935, forty-two, or 11.6%, were in the pre-school group, one hundred and sixty-eight, or 46.3%, were from seven to eighteen years of age, and one hundred and fifty-three, or 42.1%, were nineteen years of age or over.

Tables XI and XII show a classification of the cases on the basis of the major recommendations made. Table XI covers the cases for 1934, and Table XII covers those for 1935. It should be kept in mind that this table is somewhat inadequate in that in most cases more than one recommendation is made. Not infrequently several recommendations of about the same importance may be given. In all cases an effort is made to discuss with the patient or parents or guardians all of the relevant factors of the particular situation in hand. For statistical purposes, however, it is necessary to weight one recommendation or suggestion more heavily than the rest.

TABLE I

SUMMARY OF NEW CASES PRESENTED AND OF FOLLOW-UP WORK FOR 1933

Clinic Center	Number of Clinics	New Cases	Follow-Ups[X] Interviews	Clinic Load
Edmonton	52	104	118	222
Calgary	24	118	148	266
Lethbridge	12	72	66	138
Medicine Hat	1	32	---	32
Totals	89	326	332	658

TABLE II

SUMMARY OF NEW CASES PRESENTED AND OF FOLLOW-UP WORK FOR 1934

Clinic Center	Number of Clinics	New Cases	Follow-Ups[X] Interviews	Clinic Load
Edmonton	46	87	91	178
Calgary	23	78	248	326
Lethbridge	11	82	93	175
Medicine Hat	4	79	18	97
Peace River - Grande Prairie Districts	7	102	---	102
Totals	91	428	450	878

TABLE III

SUMMARY OF NEW CASES PRESENTED AND OF FOLLOW-UP WORK FOR 1935

Clinic Center	Number of Clinics	New Cases	Follow-Ups[x] Interviews	Clinic Load
Edmonton	50	103	124	227
Calgary	23	86	228	314
Lethbridge	12	90	65	155
Medicine Hat	3	61	5	66
Drumheller	2	23	10	33
Totals	90	363	432	795

x The follow-ups and interviews include interviews with, or about, provincial mental institution cases, or ex-cases. These frequently prove valuable aids in the handling and treating of the respective cases in the institutions.

TABLE IV

TOTAL NEW CASES PRESENTED AT VARIOUS CLINIC CENTERS 1929 TO 1935 INCLUSIVE

Clinic Center	Number of New Cases
Edmonton	761
Calgary	701
Lethbridge	374
Medicine Hat	172
Drumheller	23
Peace River - Grande Prairie Districts	102
Total	2,133

TABLE V

AGE AND SEX CLASSIFICATION - 1934

Age Group	Edmonton			Calgary			Lethbridge			Medicine Hat			Peace River			Totals			Percentages		
	M[x]	F[x]	T[x]	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
0 - 4	2	0	2	1	3	4	1	2	3	2	0	2	0	1	1	6	6	12	2.5	3.2	2.8
5 - 9	3	4	7	12	9	21	5	4	9	8	8	16	12	11	23	40	36	76	16.6	19.2	17.7
10 - 14	15	9	24	13	9	22	5	6	11	24	7	31	38	13	51	95	44	139	39.4	23.3	32.5
15 - 19	3	14	17	5	5	10	5	5	10	9	6	15	15	8	23	37	38	75	15.4	20.3	17.5
20 - 24	4	5	9	1	3	4	8	9	17	2	2	4	.	.	.	15	19	34	6.2	10.1	7.9
25 - 29	5	3	8	.	4	4	3	7	10	.	2	2	.	.	.	8	16	24	3.2	8.6	5.6
30 - 34	6	1	7	1	1	2	2	5	7	.	1	1	1	.	1	10	8	18	4.2	4.3	4.2
35 - 39	.	3	3	3	1	4	1	2	3	2	2	4	.	1	1	6	9	15	2.5	4.8	3.5
40 - 44	1	1	2	1	0	1	.	2	2	.	.	.	.	.	.	2	3	5	0.8	1.6	1.2
45 - 49	1	1	2	3	0	3	2	1	3	1	.	1	1	1	2	8	3	11	3.2	1.6	2.6
50 - ?	5	1	6	2	1	3	5	2	7	2	1	3	.	.	.	14	5	19	5.8	2.7	4.4
TOTALS	45	42	87	42	36	78	37	45	82	50	29	79	67	35	102	241	187	428	100%	100%	100%

[x]M - Male F - Female T - Total

10 A.

TABLE VI.

AGE AND SEX CLASSIFICATION - 1935

Age Group	Edmonton			Calgary			Lethbridge			Medicine Hat			Drumheller			Totals			Percentages		
	M[x]	F[x]	T[x]	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
0 - 4	2	0	2	5	4	9	2	3	5	2	1	3	1	0	1	12	8	20	5.71	5.23	5.50
5 - 9	10	6	16	10	8	18	7	5	12	10	2	12	2	0	2	39	21	60	18.56	13.73	16.50
10 - 14	15	9	24	14	8	22	5	0	5	11	6	17	5	1	6	50	24	74	23.80	15.70	20.35
15 - 19	14	12	26	4	12	16	5	6	11	4	0	4	2	2	4	29	32	61	13.80	20.93	16.78
20 - 24	2	3	5	2	5	7	5	2	7	3	1	4	1	3	4	13	14	27	6.19	9.15	7.43
25 - 29	2	4	6	3	2	5	5	2	7	1	2	3	1	1	2	12	11	23	5.71	7.19	6.33
30 - 34	5	1	6	1	0	1	4	4	8	0	8	8	0	3	3	10	16	26	4.76	10.46	7.15
35 - 39	7	3	10	3	1	4	5	2	7	0	0	0	0	0	0	15	6	21	7.14	3.92	5.78
40 - 44	1	2	3	0	0	0	6	2	8	1	3	4	0	0	0	8	7	15	3.81	4.57	4.13
45 - 49	0	1	1	1	0	1	3	3	6	1	2	3	0	0	0	5	6	11	2.38	3.92	3.03
50 - ?	3	0	3	2	1	3	11	2	13	0	3	3	0	1	1	16	7	23	7.61	4.58	6.33
Unknown	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	1	1	2	0.48	0.65	0.55
TOTALS	62	41	103	45	41	86	58	32	90	33	28	61	12	11	23	210	153	363	100%	100%	100%

x M - Male F - Female T - Total

TABLE VII

AGENCIES REFERRING CASES TO CLINICS IN 1934

Agency Referring	E[X]	C[X]	L[X]	M.H[X]	P.R[X]	T[X]
Schools	0	19	2	42	59	122
Doctors, including M.H.O's. and various clinics	30	21	31	35	27	144
Prov. Child Welfare, Children's Aid, Juvenile Court	32	16	8	1	0	57
Police, Provincial Jails, Other Courts	0	0	13	0	0	13
Parents, Relatives, Friends	5	7	17	1	13	43
Homes - as Mountview, Beulah, Kiwanis, Woods, Etc.	3	4	0	0	0	7
Provincial Health Dept., through some branch	6	4	3	0	0	13
Relief Department	4	0	2	0	0	6
Self	2	3	3	0	0	8
Other Agencies	5	4	3	0	3	15
Totals	87	78	82	79	102	428

[X]E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat P.R. - Grande Prairie and Peace River Districts

T - Totals.

TABLE VIII

AGENCIES REFERRING CASES TO CLINICS IN 1935

Agency Referring	E[X]	C[X]	L[X]	M.H[X]	D[X]	T[X]
Schools	1	27	1	26	1	56
Doctors, including M.H.O's. and various clinics	28	23	35	32	7	125
Prov..Child Welfare, Children's Aid, Juvenile Court	45	20	7	1	0	73
Police, Provincial Jails, Other Courts	0	0	22	0	0	22
Parents, Relatives, Friends	6	8	17	2	1	34
Homes - as Mountview, Beulah, Kiwanis, Woods, Etc.	1	4	0	0	0	5
Provincial Health Dept., through some branch	8	2	1	0	14	25
Relief Department	4	1	0	0	0	5
Self	1	1	2	0	0	4
Other Agencies	9	0	5	0	0	14
Totals	103	86	90	61	23	363

[X]E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat D - Drumheller T - Totals.

NOTE:- It may be noted that in Tables VII and VIII in the second group listed the most of the patients were referred by doctors in private practice. In the third group most of the cases were referred by the Child Welfare Department, and City Children's Aid Officers.

TABLE IX A.

CLASSIFICATION OF CLINIC CASES FOR 1934

ON THE BASIS OF AGE AND PROBLEM

Pre-School Age (0-6 years)

Problem	E.[X]	C.[X]	I.[X]	M.H.[X]	P.R.[X]	T.[X]
Examination only	1	0	0	0	2	3
Mental Deficiency	4	1	1	1	1	8
Men. Def.[X] with Epilepsy	0	1	0	1	0	2
Men. Def.[X] with blindness	1	0	0	0	0	1
Infantile Hemiplegia	0	1	0	0	0	1
Progressive Cerebral Degeneration	0	1	0	0	0	1
Epilepsy without Deficiency	0	1	0	0	0	1
Deafness and lack of Speech	0	0	0	1	0	1
Temper Tantrums	0	0	1	0	0	1
Hydrocephalus	0	0	1	0	0	1
Totals	5	6	3	3	3	20

[X]Men. Def. - Mental Deficiency.

TABLE IX B.

CLASSIFICATION OF CLINIC CASES FOR 1934
ON THE BASIS OF AGE AND PROBLEM

School Age (7 - 18 years)

Problem	E[X]	C[X]	L[X]	M.H[X]	P.R[X]	T[X]
Behavior Problem without Deficiency (I.Q. over 75)	10	15	6	6	0	37
Men.Def[X] without other specific problem	7	5	0	15	25	52
Men.Def[X] with behavior problems including theft	10	7	5	15	8	45
Men.Def[X] with sex delinquency	7	3	0	0	0	10
Men.Def[X] with physical defect	0	2	2	0	1	5
Men.Def[X] with Cerebral Diplegia	0	1	0	0	0	1
Men.Def[X] with Speech defect	0	0	0	1	0	1
Examination and report, no specific problem	0	0	0	0	15	15
Backward in school without deficiency	5	6	1	17	28	57
Definite delinquency without deficiency	4	8	0	0	0	12
Epilepsy	2	2	5	3	1	13
Psychotic, Pre-psychotic	2	2	2	1	0	7
Eneuresis	0	0	1	0	0	1
Nervousness, Stammering, Hysteria	0	0	4	0	10	14
Other Conditions	0	2	2	0	5	9
Totals	47	53	28	58	93	279

[X] E. - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat P.R. - Peace River and Grande Prairie Districts T - Totals Men. Def. - Mental Deficiency.

TABLE IX C.

CLASSIFICATION OF CLINIC CASES FOR 1934
ON THE BASIS OF AGE AND PROBLEM

Adult Cases (Over 18 years)

Problem	E[X]	C[X]	L[X]	M.H.[X]	P.R.[X]	T[Y]
Mental Deficiency with sex delinquency	3	2	3	.	.	8
Mental Deficiency with behavior problems	4	1	3	3	.	11
Mental Deficiency with physical deformity	.	1	.	.	.	1
Psychopathic Personality	.	.	4	.	.	4
Psychoneurosis, hysteria	8	3	14	3	2	30
Backwardness, instability	1	.	4	.	2	7
Psychosis(other than G.P.I.)	9	2	9	4	2	26
Syphilis, G.P.I.	.	4	.	.	.	4
General Arteriosclerosis, Disseminate Sclerosis	.	3	4	1	.	8
Encephalitis	1	.	1	.	.	2
Physical condition only	2	.	.	.	.	2
Cerebral Diplegia	.	.	.	1	.	1
Pyknolepsy	.	.	1	.	.	1
Epilepsy	.	.	2	1	.	3
Other conditions	7	3	6	5	.	31
Totals	35	19	51	18	6	129
Grand Totals	87	78	82	79	102	428

[X] E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat P.R. - Peace River and Grande Prairie Districts
T - Totals.

TABLE X A.

CLASSIFICATION OF CLINIC CASES FOR 1935
ON THE BASIS OF AGE AND PROBLEM

Pre-School Age (0-6 years)

Problem	E.[X]	C.[X]	L.[X]	M.H.[X]	D.[X]	T.[X]
Examination and report	1	5	0	2	0	8
Mental Deficiency	1	4	2	3	0	10
Mental Deficiency with Epilepsy	1	0	0	0	1	2
Epilepsy - no Mental Deficiency	0	0	3	0	0	3
Behavior Problem	2	5	2	0	0	9
Syphilis - under treatment	0	2	0	0	0	2
General Backwardness	0	1	1	2	0	4
Cerebral Diplegia	0	1	1	0	0	2
Bilateral Congenital Cataract	0	1	0	0	0	1
Stammering	0	1	0	0	0	1
Totals	5	20	9	7	1	42

[X] E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat D - Drumheller T - Totals.

TABLE X B.

CLASSIFICATION OF CLINIC CASES FOR 1935
ON THE BASIS OF AGE AND PROBLEM

School Age (7 - 18 years)

Problem	E[X]	C[X]	L[X]	M.H.[X]	D[X]	T[X]
Behavior Problem without Deficiency (I.Q. over 75)	15	10	6	9	2	42
Men. Def[X] without other specific problem	12	7	2	2	2	25
Men. Def[X] with behavior problems including theft	17	8	4	2	4	35
Men.Def[X] with sex delinquency	6	2	0	0	0	8
Men.Def[X] with physical defect	2	2	0	1	0	5
Men.Def[X] with Cerebral Diplegia	2	0	0	0	1	3
Men.Def[X] with speech defect	0	0	0	0	1	1
Examination and report, no specific problem	1	0	2	0	0	3
Backward in school without deficiency	2	3	0	13	0	18
Definite delinquency without deficiency	2	5	2	0	0	9
Epilepsy	1	1	1	0	0	3
Psychotic, Pre-psychotic	1	1	0	0	0	2
Enuresis	0	2	0	0	0	2
Nervousness, Stammering	0	3	1	0	0	4
Freidreicks Ataxia	0	0	1	1	0	2
Chronic Encephalitis	0	0	1	0	0	1
Other Conditions	0	1	2	1	1	5
Totals	61	45	22	29	11	168

[X]E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat D - Drumheller T - Totals Men.Def. - Mental Deficiency.

TABLE X C.

CLASSIFICATION OF CLINIC CASES FOR 1935
ON THE BASIS OF AGE AND PROBLEM

Adult Cases (Over 18 years)

Problem	E.[X]	C.[X]	L.[X]	M.H.[X]	D.[X]	T.[X]
Mental Deficiency with sex delinquency s	3	2	0	0	4	9
Mental Deficiency with behavior problems	6	2	3	2	2	15
Mental Deficiency with physical deformity	1	0	0	0	1	2
Psychopathic Personality, personality defect	3	0	3	0	0	6
Psychoneurosis-Hysteria	6	2	9	11	1	29
Psychosis (other than G.P.I.)	9	5	13	5	1	33
Syphilis, G.P.I.	0	1	1	1	0	3
General Arteriosclerosis, Disseminate Sclerosis	0	0	2	1	0	3
Encephalitis	0	0	1	0	0	1
Epilepsy	2	5	9	1	2	19
Tabes Dorsalis	0	0	2	0	0	2
Delinquency without Mental Deficiency	0	0	4	0	0	4
Physical Conditions	1	2	5	1	0	9
Other Conditions	6	2	7	3	0	18
Totals	37	21	59	25	11	153
Grand Totals	103	86	90	61	23	363

[X] E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat D - Drumheller T - Totals.

TABLE XI

MAJOR RECOMMENDATIONS MADE AS TO TREATMENT OF CASES IN 1934

Recommendations	E[X]	C[X]	L[X]	M.H.[X]	P.R.[X]	T[X]
Admission to Provincial Mental Hospital or Institute	12	4	12	2	1	31
Admission to the Provincial Training School or similar Institution	17	9	5	8	5	44
Treatment by own doctor or other clinic	10	3	8	5	11	37
Treatment given including direct treatment for Epilepsy	0	7	11	5	.	23
Continue home, institution, or school life, with return visits to the Clinics	4	9	2	15	30	60
Change in home routine and care, home discipline, re-education	8	15	17	9	12	61
Modified school program or special classes, including vocational training	4	11	0	26	42	83
More social contacts and wider interests, re-establishment of self-confidence	0	1	5	2	0	8
Sterilization & Supervision	9	9	3	3	0	24
Placement under careful supervision and control	15	2	7	0	0	24
Return to Clinic for further examination	3	3	5	2	0	13
Deportation	0	1	0	0	0	1
Other Recommendations	5	4	7	2	1	19
Totals	87	78	82	79	102	428

[X]E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat
P.R. - Peace River and Grande Prairie Districts T - Totals.

TABLE XII

MAJOR RECOMMENDATIONS MADE AS TO TREATMENT OF CASES IN 1935

Recommendations	E[X]	C[X]	L[X]	M.H.[X]	D[X]	T[X]
Admission to Provincial Mental Hospital or Institution	10	8	17	2	1	38
Admission to the Provincial Training School or similar Institution	22	10	3	2	6	43
Treatment by own doctor or other clinic	6	7	18	9	2	42
Treatment given including direct treatment for Epilepsy	0	2	5	1	2	10
Continue home, institution, or school life, with return visits to the Clinics	13	11	7	15	0	46
Change in home routine & care, home discipline, re-education	9	14	10	8	2	43
Modified school program or special classes, including vocational training	2	12	3	14	1	32
More social contacts and wider interests, re-establishment of self-confidence	4	0	3	6	0	13
Sterilization & Supervision	7	6	0	0	8	21
Placement under careful supervision and control	14	7	4	1	0	26
Return to Clinic for further examination	5	3	9	0	0	17
Other Recommendations	11	6	11	3	1	32
Totals	103	86	90	61	23	363

[X] E - Edmonton C - Calgary L - Lethbridge M.H. - Medicine Hat D - Drumheller T - Totals.

CHAPTER II

A STUDY OF SCHOOL AGE CASES: TEN CASES INTRODUCED

In the following pages are presented a number of school age cases which have been handled through the clinics, with an attempted analysis of the general situation in each case, and suggested remedies. In most cases conclusive results are still pending. In others, general trends of improvement, or lack of it, are apparent. In all cases we are dealing with alive, thinking, willing, human organisms, many of whom are urgently in need of careful direction and supervision.

There is a wide variety in the type of school age case referred to the clinic. There is the obviously mentally retarded child, where the problem is to ascertain the amount of retardation and outline a suitable method of carrying on so that the child may get as much as may be from his training period. The most marked of these cases are handled most satisfactorily in an institution. Then there is the child who seems to work hard but is unable to keep up with the class. There is, also, the child who seems able to do the work, but works spasmodically, if at all, and the child who can keep well up with the class with little apparent effort. With any of the above conditions there may be some disciplinary or behavior problem. There are, as well, those cases in which there is a general mal-adjustment or in which some special problem or disability is causing trouble.

In some cases things appear to be going along smoothly enough until there is an apparently sudden outburst that causes concern. Sudden outbursts are more likely to occur, probably, in cases where there is some emotional stress occasioned by mal-adjustment of some kind. Mental disease is not thought of as being common in childhood, but it may be that disorders that appear later in life have their basis in childhood to a greater extent than was thought formerly. Dr. Frankwood Williams, then a director of the United States National Committee for Mental Hygiene is quoted in "Introduction to Mental Hygiene" - pp. 48-49, as follows:- "It is commonly believed that individuals become insane suddenly. No one ever became insane suddenly. Mental disease develops over a long period of time. From small beginnings it grows insidiously, until, to the uninitiated, it blossoms forth in full bloom to the distress and consternation of those taken by surprise. And yet, before their eyes and the eyes of school teachers and ministers and friends and family physician, the thing has been developing all these years - only they have called it by other names".

We have not yet reached the stage where the average classroom teacher is prepared and qualified to pick out cases of mental retardation unaided, particularly cases where the retardation may not be very marked. To an even greater extent is it true that the classroom teacher is quite unprepared to pick out cases where symptoms of incipient mental disorder are present. In fact in many cases no differentiation is made between mental retardation and mental disease, the "dumb" individual being called "crazy", and the "crazy" individual "dumb". Too, despite the training teachers are given in their Normal School

course, they will openly and persistently tell Johnnie he is dumb and rag him unmercifully before the class - which leads to much more misery for Johnnie at the hands of his fellow students. Part of this attitude may be laid at the door of the type of training given in Normal Schools, and to the lack of any real appreciation of the whole problem on the part of the teachers when they commence their teaching work. One must remember, however, that most of the teachers are sincere in their efforts to do what is best, and that they have many things to battle against, such as overcrowded rooms, lack of adequate equipment, lack of suitable living quarters, and very often lack of salary.

During recent years the physical health and well being of the child has been receiving increasing attention, and it is not unusual for each child to receive a complete physical examination upon entering school, particularly in the larger centers. It is to be hoped that the time is not far distant when suitable mental examinations will be usual for school beginners, too. Through them much time could be saved, both for the pupil and the teacher, and much unhappiness made unnecessary. As an organization of people, we are still at the stage where we will spend large sums of money to improve our herds, grains, roads and cars, but grumble over small sums spent on our children. It has long been recognized in theory that human material is basically fundamental, but we have been slow in putting our theory into practice. It is admitted readily that much has been done, but much more remains to be

done. A great deal of our handling of human material is by the trial and error method, or no method at all. How much better off we would be if we had an accurate running record of each child as he or she passed through our schools, with results of physical examinations, mental examinations, school achievements, social adjustment, and special problems to aid us in directing future activities. And this with no idea of mechanical regimentation, but as a means to aid in guiding each individual into a suitable life course. The present state of world-wide unrest and insecurity is surely sufficient proof that we must use ourselves - human material - more wisely and efficiently if we are to save what civilization we have. We have perfected mechanical devices to the stage where the average individual can control machines capable of doing well nigh miraculous things, but there has been no corresponding increase in human stability and judgment so that the average man might be trusted to have control of such mechanical devices.

Judgment and stability are not acquired quickly. Intelligence may not be increased overnight. On the other hand, the breaking down processes in human personality do not occur spontaneously, although the manifestations of a breakdown may be sudden enough, apparently. The cases cited below may help to indicate some of the problems that we must solve if we are to aid ourselves most effectively towards a more stable, a happier and a better civilization.

The cases which follow have been chosen to

illustrate representative types of case and representative types of situation that have been encountered in the clinic work. Each case is an actual one, although no names are given. The cases have been chosen from the clinic records for the entire Province, and not confined to any one district.

The classroom situation has not been stressed particularly because each case itself includes so much more than those elements that appear in the school, although it is very often a fact that the evidences of trouble in the school, either with work or with behavior, have brought the case to the clinic's attention first. Ideally, we should be in a position to work in much closer co-ordination with the schools in the handling of problem cases. Facilities available have not permitted this to date, although in one clinic center one day from each visit is spent in examining school cases.

Each history that follows has been written with the object of presenting an intelligible word picture of the case as a whole, without the inclusion of too many details. That the histories may be inadequate is readily admitted, but they do represent pieces of work actually done. In the nature of things they are not sealed and completed. The individuals concerned are still carrying on, and creating more "history" every day. Some of them have passed out of the schools, some have not. What the situation will be in each case ten years hence no one can say, but a study of the facts so far should

enable us to make some shrewd guesses.

There are ten "cases" in the group given, although two of the "cases" deal with more than one individual - case No. 1 with a family, and case No. 2 with twins. It should be noted that these "cases" are not isolated ones, and that many more similar cases could be written up. However, it was felt that a clearer picture of the different types met with to date could be obtained by reviewing a few selected cases rather than by reviewing many very similar ones, which, if given, would have the effect of "the woods obscuring the trees".

Case No. 1:- Is that of a family of defectives. Taken as individuals they are fairly typical of the average defective of corresponding grade. These people do poorly in school and are often very unhappy there because they are constantly expected to do tasks that are beyond them. They are easily led into undesirable courses of conduct and become the unwitting tools for their cleverer companions. They are unable to appreciate the social significance of many of their acts, even though they may recognize right from wrong in simple situations. A few have tendencies that seem definitely anti-social, but most of them have not. They like to have things and see things, and get attention, and may have to resort to ways and means that do not meet with approval. Under proper training and supervision most of them are able to live happy, useful lives, but they cannot shoulder a normal load of responsibility.

Case No. 2:- Is that of twins of limited intelligence who had been encouraged in ambitions that were totally beyond them. An early diagnosis of their condition would have aided very much in directing their training and ambitions along more profitable lines.

Case No. 3:- Is that of a defective from an inferior family. This case was recognized fairly early, but proper steps could not be taken to insure the best training. This case illustrates another common course for the high grade defective, and shows how well such a one can get about, and even sell his ideas, and how plausible a story he can tell, even though it is wholly untrue.

Case No. 4:- Is that of a young girl, well developed and of good appearance, but very unstable emotionally. Her intellectual endowment was of borderline grade, but sufficiently high to have allowed her to carry on had she been blessed with a stable personality. In many situations she would, and could, pass as of quite normal intelligence. But she lacked judgment, was impulsive, and her reasoning was as erratic as her emotional reactions. This type of case is most difficult to handle successfully. In many ways the individuals are so close to normal that a normal reaction is commonly expected. A prolonged period of careful training is essential, and this is seldom possible. Even with this one cannot be sure of results. If the emotional trend is religious, we may have a religious fanatic of the most unstable type. Or there may be excesses along any one of a

number of other lines. All too often the home background these cases have is none too good, although this is not always the case. This type of case can be so repentant over wrong doings, and so full of good intentions and promises - and so easily tempted over the line into misbehavior again.

Case No. 5:- Is that of a teen age boy of normal, or better, intelligence, who persisted in misconduct, partly because of a faulty personality make-up, but mainly, one feels, because of poor home training. Given an initially poor home situation and aggravate it with a common-law-wife-husband situation, and an aggrieved attitude on the part of the mother, and the situation is bad. There is the feeling of insecurity in regard to the home, the fear of public disapproval, and in this case the fostered attitude, really one of defence, that "the other fellow" is to blame. Among other things this case shows the undesirability of allowing a boy, or girl, to place all the blame for any course of action on other shoulders. The attitude becomes a rationalized habit, and a very injurious one. The trouble was diagnosed fairly early, but the boy and his parents would not accept this and work to correct it. Now a period in an industrial school may, but it is doubtful.

Case No. 6:- Is that of a boy of normal intelligence who got into behavior trouble. The family background in this case was much better than that in Case No. 5, the personality was better, and there was much better co-operation in effecting a re-adjustment. The results were

very encouraging, and further serious trouble is not looked for.

Case No. 7:- Is again that of a boy of normal intelligence, but this time the problem has to do with night terrors and sleep walking on the part of the boy, and worrying fears which the mother had and which she was allowing to influence her to too great an extent in her handling of her family. The remedy depended as much on educating the mother to adopt a different attitude as it did on attempting to aid the boy with his specific trouble. Results have been encouraging.

Case No. 8:- Is also that of a boy of normal intelligence but with a problem of still another type. This time over-sensitiveness on the part of the boy and lack of appreciation of this fact on the part of the teacher, produced results which were nearly tragic, almost costing the lad his life. This case brings into relief the thoroughly pernicious habit of attempting to secure better academic results from school children, and particularly public school children, by use of ridicule and sarcasm. The practice is to be frowned down upon in every case. The teacher would gasp with horror at the suggestion that she had broken a child's arm, yet she may go serenely along breaking down his morale and emotional balance, which is far more serious from the standpoint of his life and adjustment.

Case No. 9:- Is that of a young girl already showing signs of an early schizophrenic reaction. She had a broken

home, and positive heredity through her mother to contend with. Suggested treatment and placement in a better environment have produced some improvement. It is hoped that the improvement will continue, but that remains to be found out. There are relatively few cases in public school as pronounced as this, but there are a number who show a tendency to a schizoid type of reaction, and who would stand a much better chance of escaping trouble later on if they could be appropriately handled during their school years.

Case No. 10:- Is that of a teen age boy of normal intelligence who developed a frank psychosis. Some factors in this situation were disagreement between the father and the mother which led to a home broken up, the death of the father, and economic stringency under the mother's care again, and rather unwise handling on the part of the mother and grandmother. The boy is recovering from his illness, but a recurrence is not unlikely, especially should he be subjected to any undue stress in the future.

CHAPTER III

A STUDY OF SCHOOL AGE CASES: CASES CONSIDERED IN DETAIL

Case No. 1

The "X" Family - Defectives

This family was first brought to the attention of the clinic in 1933, because of suspected immoral conduct of at least two of the children, coupled with marked backwardness in school progress. The following is an outline of the situation as it existed then, and further developments are noted as the case progresses. While not all of the children were in school when the case opens, all are included in the history to give a more complete picture of the whole situation.

Family History and Situation:- Mr. "X", the father, had died a few months previously of a cardio-renal condition. For years, and up to a year or so before his death, he had been a confirmed alcoholic. He had not made a good adjustment socially or economically, and had supported the family by doing various sorts of laboring work, and more latterly by acting as the town constable. All accounts would indicate that his intelligence was not above average, at best.

Mrs. "X" had secured the Mothers' Allowance following her husband's death, and was carrying on trying to hold the family together. She was well meaning and inoffensive in attitude and tried hard to do what was right. The task of looking after the family unaided was just too much for her. There were many indications that she was mentally subnormal,

but no formal rating was secured.

Little information regarding the family background could be obtained from Mrs. "X", and she knew little about either her own family or her husband's. Nearly all the relatives on both sides of the house still live in Scotland. Mrs. "X" said that she did not know of any heredity of mental or nervous trouble.

Siblings:- The following table gives the ages of the various children in 1933, and brief notes on each. The female children are noted as F. 1, F. 4 -- the numerals denoting position in the family, the oldest child being designated as 1. The male children are noted as M. 2, M. 3, etc. The abbreviation C.A. is used for chronological age, M. A. for mental age, and I. Q. for intelligence quotient.

TABLE XIII

SIBLINGS OF THE "X" FAMILY - 1933

Children	C. A.	M. A.	I. Q.	Grade	Remarks
F. 1	25	?	?	4	Had illegitimate child at 19 years. Now working in butcher shop.
M. 2	21	?	?	4	Working steadily - no problem.
M. 3	16-1	9-4	58	5	Left school this year - our of control. Sex interested and relationship with F. 4 suspected.
F. 4	14-6	7-0	48	3	Pleasing personality; is unmoral. Had sex relations at school and others suspected.
M. 5	12-7	7-9	62	4	No problem yet.
M. 6	10-2	8-9	86	4	No problem yet.
F. 7	8-9	5-9	64	1	Close associate of F. 4 - rather a problem.
M. 8	7-9	6-0	77	1	No problem.
F. 9	3-11	3-6	89		Subject to convulsions.
M. 10	1-11	?	?		Probably dull normal.

Personal Histories:- No abnormalities of birth were noted. All the children were full term babies. The usual childhood diseases have gone through the family, but no serious after effects have been noted. The developmental ages have been somewhat retarded throughout the family. All of the children were born in Alberta. There is a history of convulsions in only one case, F. 9, and these appear to be epileptic in nature. The general physical health of the family has been fairly good.

School progress has been unsatisfactory in the case of each child. F. 1, and M. 2 reached grade four at fifteen or sixteen years. M. 3 reached grade five at fifteen years. F. 4 reached grade three at fourteen years, and so on. M. 6 alone is making fairly satisfactory progress, and this could not be called good. The general school adjustment has been unsatisfactory. The children are poorly mannered, inclined to be quarrelsome, and the language they use is rough, and at times profane. There has been a definite sex interest shown by all the members of the family when school age has been reached.

Case:- The original complaint, as noted above, was that two of the children, M. 3 and F. 4, were accused of sexual misconduct, and mental deficiency was suspected. The original investigation resulted in the gathering of the data given in Table XIII, and the facts noted regarding the general family situation.

The original recommendations were that M. 3 and F.4

be admitted to the Provincial Training School for training, and that contact be maintained with the rest of the family so that any further supervision or action could be taken. Due to a lack of sufficient personnel, the supervision and direction possible proved inadequate.

M. 3 and F. 4 were admitted to the Provincial Training School, M. 3 in November 1933, and F. 4 in January 1934. M. 3 responded to training quite well and adjusted well in the School. On a psychometric examination given in the School he earned an I.Q. of 57, which is in close agreement with that of 58 earned previous to his admission. He was presented to the Eugenics Board for Alberta in March, 1934, and passed by them. The operation for sexual sterilization was carried out in May, 1934. M. 3 was given a considerable period in the School following this, and continued to improve in personal demeanor and conduct. He has been out of the School for a time now, and is adjusting better. Indications are that he will be able to carry on with some supervision and direction.

F. 4 showed no particular improvement as a result of training, although she gave no special trouble so far as school routine was concerned. A psychometric examination done at the Training School gave her an I.Q. of 49, just one point above that previously earned. She is still undergoing training at the School. Her case was considered by the Eugenics Board in March, 1934, and the sterilization operation was carried through in April, 1934.

There was a further definite complaint early in 1935 in regard to F. 7 and M. 8. There had been further sexual trouble and further investigation revealed that F. 7, now ten years old, had been having sexual intercourse with several boys of about her own age at school, and also with some Chinese adults in the town. M. 8 was implicated also, and probably other members of the "X" family. F. 7 was suspended from school for an indefinite period.

A check psychometric test done on F. 7 gave her an I.Q. of 67. On a previous test she had earned one of 64.

Immediate admission to the Provincial Training School was recommended for F. 7, and this was arranged. M. 8 has been carrying along at school and at home somewhat more satisfactorily, but not in a really adequate manner. Both children would certainly benefit by a period of specialized training in an institution such as the Provincial Training School, but the necessary accommodation is lacking.

It is of interest to note that M. 2 married in 1936, despite efforts on the part of the town authorities to prevent it. M. 2 would not agree to having his case come before the Eugenics Board. More definite efforts were made to prevent F. 1 from marrying, at least without being sterilized, but these efforts were unsuccessful, despite the assistance of Mrs. "X". F. 1 had been carrying on with a young laborer who appeared to be definitely subnormal. They were married in 1936. One can predict that both F. 1

and M. 2, and their marital partners, will bring numerous children into the world, a number of whom will be defectives. In the years to come the State will, undoubtedly, be called upon to contribute substantially to their support.

Of the family of ten only two have been sterilized to date. It may be that others will be before they reach the childbearing age. That every member of the family should be sterilized is our belief. With at least six of the ten siblings of the family definitely defective, and one of the others epileptic, there would seem little chance of their offspring being mentally normal, especially as they are likely to mate with those of about their own mental level.

The clinic offers a service for the early diagnosis and recognition of such cases as the above, and as well a service to aid in their supervision and training. Careful studies of other similar cases over a much longer period of time have revealed the trail of tragedy, incompetency, disease, and unhappiness that they leave down through the years. This one family, not an isolated case, shows that we in Alberta have our own definite problems in this regard.

Little information could be obtained about F. 1's illegitimate child. It has not been seen to date.

Case No. II

Male Twins - Subnormals

This is a case of twin boys, very much alike but not identical. They are the sons of a bank manager and have an excellent home. The father had great hopes for these boys and had planned professional careers for them. He wished one of them to be a doctor. When referred to the clinic they were nineteen years old and still in school. One had been pushed along to grade eight and the other to grade nine, although neither was doing acceptable academic work. They had been allowed to continue school partly because of the family position in the town, partly because the boys themselves gave no trouble from a behavior standpoint, and partly because they tried hard. The parents, and also the school board, realized that something was not right, and wished a definite diagnosis and recommendation.

The outline and history of the case was as follows:-

Family History:- (father) 46 years old. His general health had been good, although there was a history of some indefinite spinal trouble at about thirty-six years of age which caused inflammation for a time. There was also a history of a recent "nervous breakdown" for which no institutional treatment was required. The father is of Scotch descent and inclined to be phlegmatic in temperament. He has been very much concerned over the boys. There was no history of any mental or nervous disturbances in the

family. The father re-married following the death of his first wife.

(Mother) The boys' own mother died of tuberculosis at the age of forty-two years, when the boys were quite young. Otherwise the family history on the mother's side appeared clear.

The step-mother is a fine type of woman, and the boys get along well with her.

Personal History:- The personal histories of the boys were very similar. In each case there were feeding difficulties, and a general retardation in developmental ages. Eliminative control was late in being established. There were no convulsions. One boy was a tuberculosis suspect for several years, but was finally given a clear health bill in this respect several years before he was seen at the Mental Clinic. There was no history of any serious physical illnesses. The history indicated quite definitely that the condition of general retardation had existed from birth. There were no other children in the family.

Physical examinations given at the time of the clinic visit showed the boys to be in good physical health. Neurological examinations gave negative results.

Intelligence tests, using the Stanford Revision of the Binet Test, on which co-operation was excellent, gave results as follows. J. earned a mental age of fourteen years and two months, and an intelligence quotient of 89.

His basal age was ten years with two test items passed at the sixteen year level. J's. vocabulary rated at the sixteen year level, partly because of the somewhat superior environment he had lived in and the very careful training in English he had received. B. earned a mental age of twelve years and two months, and an intelligence quotient of 76. Again the basal age was ten years but no test items were passed above the fourteen year level. B's. vocabulary rated at the fourteen year level.

In personality both boys were friendly and open, and were well liked. There was a tendency in each case for the boys to associate with younger boys, although they got along well with adults. Both boys were rather discursive in conversation. Each was ambitious above his capacity. B. said he wished to be a designer of automobiles. He had some special ability in drawing. J. said he wanted to be a professional athlete and trainer, for which he had neither the ability nor the physique. J. was somewhat more irritable than B. and tended to lose his temper easily. Neither boys had a normal appreciation of money values, which may be blamed in part on faulty training in this regard.

Recommendations:- It was recommended that both these boys be allowed to discontinue school, and that their interests be directed away from their too ambitious plans and oriented towards vocational types of work of which they are capable. Some suggestions made in regard to J. were

gardening, garage work, poultry raising and sign or decorative painting. Gardening, garage work, and poultry raising were suggested for B. also, but it was pointed out that he would need a greater amount of supervision and direction than J.

Developments:- These boys have been allowed to discontinue school and to spend a great deal of time on a farm the father has. They have been making a fair adjustment now under these conditions for over two years, and the family appear to be reconciled to the made changes in their plans. One gets the impression, however, that the father is allowing them to "play" at farm work, and is not preparing them effectively to carry on more independently. What may happen when his guidance is removed is hard to say. The influence that the stable, cultured home atmosphere has had on these boys can hardly be over - estimated, and under any circumstances will aid them in adjusting.

Case No. III

Male - High Grade Deficiency

"D" paid his first visit to the clinic in 1930, accompanied by his mother, who had brought him because he had been doing poorly in school, had been running away, and had been generally unreliable. The case is included to show some of the variations one finds in this type of case, and also to note further the part played by family

background and home life.

Family History:- The father was forty-eight years old in 1930, and the mother six years younger. The father was a labourer who was finding it very hard to get along. Since 1930 the family have been on relief much of the time. The father's health was good and no adverse heredity was elicited. The mother was not robust; in fact she was a semi-invalid who found it hard to keep her home in even fair condition, and harder to keep control of her family. Again no adverse heredity was elicited, but it seems entirely likely that there is some history of adverse heredity on each side of the house, could all the facts be found out.

The mother and father appeared to get along fairly well together, but at best the home was a poor one.

There were five siblings, of whom the oldest was eighteen years and the youngest six years. The oldest child, a girl, was in the Provincial Training School, having been committed there following sex delinquency. Her intelligence quotient on a formal test in 1927 was 55, and on a re-test in 1930 it was 57. "D" was fourth in the family. The other siblings were making fair progress in school and were giving no particular trouble.

It may be of interest to note here that the sister who was in the Training School was discharged to her home in the late summer of 1931, after her case had been considered by the Eugenics Board and she had been

sterilized. Since her discharge she has stayed at home most of the time. She has worked out for short periods doing menial domestic work. She married in 1936, and she and her husband are both at home with her parents now.

Personal History:- "D's" birth and early developmental history were reported as normal, except in talking. He did not talk until late and when he was four years old he could say only a comparatively few words. When he first came to the clinic he was still definitely limited in his language ability. He had never had any really serious illnesses and had never had convulsions. He had been somewhat of a problem since pre-school days. In 1930 he was eight years old and already giving trouble, as noted above.

There had never been much of a chance for "D", or the other siblings, to enjoy pleasurable play or social contacts at home, and "D" started to find his pleasures away from home.

Clinic Examinations:- Physical examination did not reveal any gross defect, and "D" appeared in fairly good condition.

A mental test gave him an intelligence quotient of 75. He co-operated well and appeared to do his best. He showed more aptitude for arithmetic and number problems than he did on the language tests.

A complete re-examination was made in September, 1936. Physical condition was quite good, although there was some larging in the appearance of the secondary sex characteristics. On a mental re-test, "D" earned an intelligence quotient of 71. This checks closely with the intelligence quotient earned previously, especially as a note made in 1930 states - "This (I.Q. 75) may be taken as the upper limit of his present ability, as on one or two of the tests he was given the benefit of the doubt where his responses were none too clear".

It was recommended in 1930 that "D" be allowed to attend a different school where he would be able to make a fresh start in new surroundings, and where the situation could be explained to the school authorities before he arrived. Also, some steps were to be taken to try to improve the general home conditions.

Developments:- "D" was allowed to go to a different school, and made a better adjustment for a time. However, from 1930 to 1936 there were fairly frequent outbreaks of trouble of a minor nature. The family moved about the city a good deal, and "D" was in several different schools as a result. He would run away occasionally, lie more than occasionally, and do some petty thieving. His school progress was unsatisfactory, but he was pushed and pulled along until in 1936 he found himself in grade six.

In September 1936 "D" came up in Juvenile Court, charged with numerous thefts. He was referred to the clinic for a complete re-examination, with the physical and

psychometric results noted above. "D" said that he had a great admiration for an older brother who had gone off "beating his way", and who was then in San Francisco. According to "D" this older brother had been "all around the world nearly". "D" showed a considerable amount of interest in farm work. His personality was extrovert and he was quite pleasant and co-operative.

It was recommended that he be tried out in a good farm home first, before more severe measures were resorted to.

An enumeration of what happened in the one month of September may be enlightening. He was in Juvenile Court on September 1st. 1936, charged with thefts, as noted above. He was then re-examined at the clinic with the above results. He was made a Ward of the Superintendent of Child Welfare and temporarily placed in a city shelter. He ran away and was picked up forty-five miles away, and returned. He was immediately placed in a "splendid farm home" about one hundred miles away. The day after he arrived "he ran away, taking the dog with him and leaving his clothes". On September 29th. a wire was received from the police in Winnipeg saying "D" was being held there.

He was returned from Winnipeg, and he settled down for the winter, or for part of it. He was allowed to remain at home and go to school, and he behaved fairly well.

Early in February there was another definite break. He ran away from home and decided he would go to the West

Coast. He found his way to a Child Welfare officer, one who, as it happened, did not know him, and very convincingly stated that his home was in Vancouver. His father was dead. He had foolishly "beaten" his way to Alberta but now wanted to get home, and he gave a house number and street. The Welfare officer wired for confirmation, which, of course, he did not get. In the meantime "D" was recognized. It was found out as well that he had been pilfering regularly in one of the larger stores in the City.

It had become all too apparent that "D's" parents were wholly unable to control him, and that he was rapidly nearing some very serious trouble. The clinic further recommended - "To avoid this, if possible----would suggest that he be placed under custodial care, preferably in a boys' school where due attention is given to vocational as well as scholastic training, and where character training and intelligent discipline are stressed.-----If the B.-- School meets these conditions, -------strongly urge that early steps be taken to have him admitted".

What will the outcome be in this case? It is very hard to say. With initially inferior material to work with the outlook is none too hopeful. The years of lack of training have made themselves felt, and the mental sub-normality has encouraged a straying from socially acceptable usages. Given a stable helpful home environment, "D" might well have escaped trouble and settled down to some useful occupation, under supervision. Our schools do not make sufficient provision for this type of case, and do not provide sufficient training opportunities of suitable types. There are interesting jobs that "D" can do, but he has not

discovered them.

Case No. IV

Female - Borderline Deficiency

This is the case of a school age girl who was referred to the clinic through the Department of Child Welfare. She had reached grade five at that time. She first attended the clinic in July, 1934. Since then there have been frequent contacts, which are still being maintained. She was referred primarily because she had proved a decided behavior problem with emotional instability, and had not made normal progress in school.

The facts of the case are presented below.

Family History:- When the clinic file opens the father was fifty-one years old. He had been born in the United States, was normally healthy, and was then living on a farm. Subsequent information would indicate a religious turn of mind, of the type that likes to parade his religion. He was a Protestant. He had drifted about a good deal, working considerably as a rig builder in the oil fields.

The mother was forty-one years old in 1934. She also was born in the United States. Her health had not been very good, and she was reported as being quite nervous.

No other adverse heredity was elicited on either side of the house.

Siblings:- (1934) There was one sibling older than the patient and three younger. The elder sister, F. 1, was eighteen years old, and living at home. She was said to be in good health. She had reached grade six at fifteen years. M. 3, a younger brother, was thirteen years old and in grade four. He was referred to as a "dumb egg". F. 4, a younger sister, was eleven years old and in grade two. None of the other children had given any particular trouble, and all were regarded as healthy, normal children, except for M. 3's "dumbness". There has been no opportunity to secure mental ratings on any of the children other than the patient.

Personal History:- Birth and developmental history are normal. There had been the usual childhood diseases, but no really serious illnesses. The patient had always lived at home. She had worked out for short periods of a few days at a time.

She had always been difficult to manage. She was self-willed and impetuous, fond of company, and of adventure. By 1934 she was completely out of control, so far as her mother was concerned, and was only partially under the control of her father.

School History:- This was none too encouraging. She did not do well in an academic sense, but took an active part in the general activities of the school. She was fond of school festivals, dramatization and such like. She got along fairly well with the other pupils. She was inclined to be irregular in attendance, and hard to control.

Case:- Information indicates that in the Fall of 1933 the patient ran away from home, riding off on a horse that did not belong to the family. She was away several days before being brought back, and had spent one night in a truck with several men. This was the most serious of several similar escapades. There were charges that she had stolen at different times a variety of articles such as "blankets, money, and whatever she could lay her hands on".

In November, 1933, because of additional trouble, the case came up in Juvenile Court, and the patient was placed under the Superintendent of Child Welfare, but allowed to go home. For some months she appeared to make a much better adjustment, but in the Spring of 1934 she got in with a rough "fast" crowd, and there was a succession of parties and dances on which smoking and drinking were common, and sexual indiscretions took place. It was found necessary to remove her from the home environment entirely.

According to the girl's own story a factor in the home situation causing constant irritation was that her sister, F. L, was given many small preferences which irked the patient.

The clinic examination did not reveal any marked physical defect, although there was a heart murmur and a slight enlargement. General development was good, and the girl had quite a pleasing appearance.

A psychometric examination gave a mental age of twelve years and nine months, and an intelligence quotient of 80. A subsequent test gave an intelligence quotient of 78, which checks closely.

In personality the patient created a good initial impression, but showed emotional instability. There was a noticeable extrovert tendency and a rather vivacious manner.

Developments:- Following the clinic examination, in July 1934, it was recommended that the patient be placed in a good environment away from home, where she would have an opportunity to adjust more satisfactorily under suitable conditions and supervision. She was tried out in several good homes, but her emotional reactions were so unsatisfactory that she was sent to a social service home for girls, in Calgary, where she remained until May 1936. While there she gave considerable concern by her impulsiveness and instability.

A clinic re-examination during the period in Calgary showed no essential change in physical or mental health or capacity. In view of the history of the case, and the continued lack of proper adjustment, it was recommended that she be seen by the Eugenics Board. Her case was reviewed by them, and the directed operation was carried out just after she left Calgary.

She was allowed to go home on her recovery, although the outlook did not seem very hopeful. One point in its favor was that the family had moved into a new

district and the financial circumstances seemed better.

In the months that this patient has been home again she has had several quarrels with her parents, and at the time of writing is working away from home. She is engaged to a young laborer of none too desirable a family, and they plan to marry this year, if possible. She is continuing to show her impulsiveness and instability, and we may expect that her future will continue to show waywardness. That she will have to be institutionalized again is a very distant possibility. What could have been accomplished if she had been under adequate training and supervision from an earlier age is a question that cannot be answered, but such a course would have been full of possibilities.

Case No. V

Male - Psychopathic Personality

This case came to the attention of the clinic first in November 1929. The lad was then between seven and eight years old, and had already been in considerable trouble for one so young. He was playing truant from school, causing trouble by his mischievousness while at school, being disobedient, staying away from home, and doing some petty thieving. He was in grade one at school and not doing satisfactory work.

The general background of this case is quite interesting and instructive, and is given below in some

detail, as it is known.

Family History:- The boy's father was a Ukrainian bootlegger who operated in the Alberta - United States border territory. No definite history could be obtained in regard to his family, but that he was not of a high type can be taken for granted. He deserted the boy and his mother when the boy was six months old. He subsequently served a jail term for his bootlegging activities.

The mother was of average intelligence but rather unstable emotionally, and was, in many ways, anti-social in attitude. No definitely adverse hereditary family history was elicited. After the father left her and until the boy was six years old she worked as a waitress. The boy had to fend for himself a great deal, staying wherever the mother happened to be working, and boarding most of the time under no adequate supervision. He was placed with an aunt for a time, but the history indicates that the aunt went to extremes of strictness with him, causing marked resentment because of this. He was placed in the Lacombe Home for a year, and did well while there.

When the boy was about six years old the mother established a home again with a railway trainman. Apparently they were married, but actually there had never been any legal marriage, one reason being that the mother had no divorce from her first husband. However, for practical purposes she re-married in effect, and took her common-law husband's name, as did the boy. The step-father

took an immediate interest in the boy, whom we shall call "P", and has been very good to him throughout. The step-father is a man of at least average intelligence and of quite a pleasing personality, although his judgment has not been good in dealing with the boy.

At the time of the first clinic contact with the case, the family were living in rooms, and there was a small six-months old baby, a half-brother to "P". The family quarters, in a city block, allowed very little room for "P" to play inside, and none at all outside except on the street. Since then the family have moved to a house of their own. Also, there have been two other children born. None of the three half-siblings is showing abnormal mental or physical symptoms to date.

Personal History:- The personal history has already been outlined to the time "P" was seven years old. There were no developmental abnormalities, and no serious illnesses. "P" had learned the "ways of the world" rapidly, and at seven years was sophisticated much beyond his years, and adept at looking after himself on the city streets.

Clinic Examinations:- Examinations at the clinic in 1929 showed "P's" physical health to be good, although there was some indication of slight undernourishment. Mentally he earned an intelligence quotient of 114 on a formal test. Co-operation was good, but the worldly wise attitude was apparent. There seemed no realization of what his then line of conduct would lead to, although there was

nothing very abnormal in that, taking his age into consideration.

Recommendations were made that he be advanced a grade in school, as he was not working anywhere near his capacity; and that the situation be gone over carefully with the parents in an effort to assist them in handling "P". Failing a satisfactory adjustment at home the clinic recommended a further period in the Lacombe Home, where he had made a good adjustment previously.

Developments Since 1929:- For a time things went along more smoothly. "P" did better in his school work, his behavior was better, and he seemed more under control at home. However, there continued to be trouble which tended to increase in seriousness. For several years "P" was able to "get by" as it were, with relatively long periods free from any particular trouble, and with the troubles he did have smoothed over by his step-father and his mother. The following will give an idea of his delinquent activities.

"P" said that he was taught to steal in 1930 by two older boys. The three boys would play truant together and do petty pilfering, "P" being, very often, the one to carry out the actual theft. In this connection it is of interest to note that the other two boys are mentally deficient. One is now in the Provincial Mental Institute, and one is in an industrial school outside of the Province. Stealing from Woolworths started in 1930, and "P" was

checked for this. In 1932 he got in with another group of bigger boys and began to steal bigger things, such as toys and electric train engines. The other boys kept these things but "P" got sufficient thrill out of being smart enough to get the desired articles. In 1932, also, he stole a bicycle. This was returned and the case was dropped. There follow some other minor thefts to April, 1935, when he and two other boys stole an automobile and drove it around for some hours. They were caught and the Juvenile Court judge placed "P" and one of the other boys on suspended sentence, and under the Superintendent of Child Welfare. They were placed on farms in a new district.

In July 1935, "P" was back home again, with new petty theft charges against him, and also charges of running away from where he was placed. He was brought back to the clinic for a complete re-examination.

There were certain personality traits that were well marked by July, 1935, but which had been gradually developing. There was a marked aggrieved attitude, and a complete lack of willingness to take the blame for anything. There was also marked untruthfulness, and an apparent utter disregard for promises once they were made. There was also a tendency to sulkiness, and his expressed principles and ideas were anti-social. Outside information and a talk with the mother showed that she shared in the boy's general attitude and projected his failures to others.

Physical and neurological examinations revealed no physical basis for his misconduct, and "P's" general health was good.

A psychometric test gave him an intelligence quotient of 107. He had earned an intelligence quotient of 114 in 1929. It was felt that the drop of seven points was due, in part at least, to some let down in co-operation because of his general attitude. He was in grade seven in school.

In view of all the factors in the case a diagnosis of "Psychopathic Personality" was made. It was recommended that he be placed in an industrial school if the parents could not control him, the industrial school being the only available institution at all suitable.

Developments were even more rapid following July 1935. "P" got into more trouble and was committed to the industrial school. He was only there a short time when he eloped and found his way back home. Instead of being returned to the school at once the authorities allowed him to remain home. For a short time things went better and "P" had a job as a delivery boy. When this failed his trouble broke out again, and he was implicated in further petty thefts, and further taking of cars for "joy rides". Largely through the influence of the clinic he was given one last chance to adjust at home. Again the situation was gone into carefully with the boy and his parents. It was pointed out that it was absolutely essential that "P"

should assume his fair share of blame, and that the parents must not aid in fostering an attitude of projection. Efforts were to be made to get "P" a job, and "P" promised to do his best.

"P's" best was very bad. Within a few days trouble started again - there were more thefts and another car taken, and again "the other fellow's fault". Also, information came out that "P" had been implicated in a number of other previous affairs of a fairly serious nature, including a charge of tampering with the mail. No other course being open, "P" was sent to the industrial school, where he still is, although he had vowed that he would get away. "P" is now fifteen years old.

The outlook is not good. What would have been the result if he had had a good home environment, particularly during the pre-school years, we may only guess. Certain it is that the home does play a very important part. A home, a safe retreat from the batterings of the outside world, a place where one "belongs", is of inestimable value at any time in life, and especially so during the formative years.

Case No. VI

Male, Normal Intelligence - Behavior Problem

This case, that of a boy of eleven years, came to the clinic in 1931. He was then in grade four and doing fairly well in his academic work, although he had repeated grade three three times. The patient was referred primarily because he had been implicated with five other boys in stealing cars for "joy rides". The oldest of these boys was sixteen years, the youngest, the patient whom we shall call "Y". It is interesting to note that of the six boys the oldest one was definitely a defective, with an intelligence quotient of 56. "Y" secured the highest rating of the group, earning an intelligence quotient of 107. The other four boys had intelligence quotients ranging from 88 to 95.

Family History:- The family history was negative so far as could be found out. The father, then thirty-eight years old, was normal and healthy. The mother was thirty-six years old, normal and healthy. They were of Scotch extraction. They had been married seventeen years, and had gotten along well together. The father was a truck driver. There were six children in the family, of whom "Y" was the third. The other members of the family of school age were making average school progress, were normally healthy, and had given no trouble in a disciplinary or behavior way.

Personal History:- "Y's" birth and developmental history were normal, with no history of any serious illness or convulsions. "Y" had always been an active, friendly child who got along well with others and had numerous friends. He had a pleasing appearance and an open frank countenance. He gave no trouble at home. The trouble which occasioned his reference to the clinic was the first there was record of, other than very minor disobediences.

School History:- "Y" started school at six years, and the first three years he made a grade a year. Then he spent three years in grade three. It seems that he was allowed to go through the first two grades without receiving the grounding he should have had and being allowed off on some portions of work because of his bright manner and pleasant ways. He began to capitalize on these and did not do his work, so finally "rested" in grade three. His intelligence was not sufficiently high to allow him to go along without an average amount of work.

He gave practically no trouble in a behavior way in school, although he was whipped once for striking a match during a class session.

Case:- "Y" and five other boys were charged with having stolen several cars for "joy riding", as mentioned above. They would take a car and drive it around the district for a few hours and then leave it somewhere and go home. Each boy would take a turn at driving the car, the entire object of the adventure seeming to have been

to have a good time. The cars were not wilfully damaged and were left about as the boys got them, except for the gasoline and oil used. They were not used to aid in other misdemeanours. Finally the "gang" was caught and the boys appeared in Juvenile Court. They were referred to the clinic for examination before the cases were disposed of.

Clinic Examinations:- Physical and neurological examinations gave essentially negative results. "Y" was in good health and well nourished.

On the psychometric examination "Y" earned a mental age of twelve years and five months, and an intelligence quotient of 107. He co-operated well and his responses were of good quality. His grasp of general and school knowledge was normal.

"Y's" personality has already been commented upon. He could give no adequate reason for his actions in the car episodes except that he got with the group and then followed the lead of the others. He admitted that he enjoyed the adventure of it.

It was recommended that "Y" be supervised more carefully, and that his companions be chosen, to the extent that he was to keep away from the other members of the "gang" at least. His movements at night were to be under special control. It was recommended, also, that "Y" be given a chance to go to the Y.M.C.A. and join some

of the activities and boy's groups there. He was to come back to the clinic every month for a time for a friendly talk.

Developments:- Efforts were made to carry out the clinic recommendations. "Y" came back one month after his first visit, accompanied by his mother, and good progress was reported. He had joined the "Cubs", he had been in no further trouble, and his school work was showing improvement. Two months later he was doing well still. He had joined the Y.M.C.A. and was enjoying the activities there. There had been no further trouble and the old gang associations seemed to be broken up. "Y" himself seemed quite pleased with his progress. Six months later there was a similar report. At this time "Y" was keeping some rabbits as pets and was much interested in them.

"Y" continued to do well for ayear and a half following his first visit to the clinic. Then further trouble occurred. An older boy stole a purse with nearly $50.00 in it and several of the other older boys, some of whom "Y" had been associated with in the car stealing, found out about it. They persuaded "Y" to lead the boy with the stolen money into a "trap" or "ambush" whereupon the others set upon him and took most of his stolen money away from him. "Y" was to be given $1.00, but he claimed he refused to take it.

"Y" was let off with a warning, which he apparently took to heart, for there have been no further reports of

misconduct. He has continued to make normal progress in school, and shows promise of making a good adjustment when he completes his school work. He may not get a chance to complete high school, as the family's financial status is not good.

This was the case of a normal boy who sought an outlet for his adventurous spirit in conduct which was anti-social, but could not be called criminal. He realized the error of his ways and with some assistance and direction he was able to re-adjust himself so that his activities could be approved.

Case No. VII

Male - Sleep Walking and Night Terrors

This is the case of a boy first brought to the clinic in March, 1935. He was not referred initially through the school, but it is felt that he belongs to the school group of cases, because of his age, eight years, and also because a continuance of his condition would be reflected very soon in his conduct and progress at school. When he was brought to the clinic he was having night "spells" about every other night. The night terrors had been present for some time, but the sleep walking had been present for a few months only. He was a very active boy, interested in things about him and in school. He was in grade two and reported to be doing quite good work.

His conduct was "excellent".

Family History:- The family on the father's side was reported as being without any positive heredity for mental disease or deficiency, although there were some other members of the family high-strung and nervous. The father himself was twenty-nine years old and healthy. He had a public school education. He had been an iron foundry worker, but was on relief in March, 1935. On the mother's side there was some positive heredity. Her father had had a mental breakdown at forty years, and has been in a mental hospital ever since. His case was diagnosed as - "Schizophrenia - Paranoid Type". The mother, twenty-seven years old, was one of six children, of whom the others were reported healthy and normal. The mother herself was of normal intelligence but a great worrier. She worried excessively over the children, and particularly about whether or not they would inherit any tendency to mental disorder. Her worry over this last, combined with other factors, produced a mild depression. Several visits to the clinic and re-assurance have tended to aid her in overcoming her undue fears.

The parents had been married nine years and marital life was harmonious.

Personal History:- The patient, whom we may call "T", was born in Saskatoon, but lived most of his life in Alberta. His birth and developmental history were normal. There is no history of convulsions. He had had several

severe colds, including one in 1933 when the cold settled in his head and face and he had to have his gums lanced because of the formation of pus. Later in 1933 he had an appendectomy, from which he made an uneventful recovery. He had had chickenpox previous to this first visit to the clinic, and he has had a light attack of whooping cough since.

"T" has always been an obedient, truthful, pleasant boy. He has occasional flares of temper, from which he quickly recovers. He is rather easily teased, and there is a history of his having been teased excessively by adults when a pre-school child.

A physical examination in 1935 showed his general physical health to be good. However, he was a little underweight, he had several carious teeth, and enlarged fibrous tonsils.

A mental test gave "T" a mental age of eight years and three months, and an intelligence quotient of 103. He co-operated well in the test and responded readily. Basal mental age was eight years and no items above the nine year mental level were passed.

"T" started school at six years, and has made good progress from the beginning. He likes school and has given no trouble from a behavior standpoint. He gets along well with others in his age group.

Case:- The main problem has already been mentioned - i.e., sleep walking and night terrors. This proved

particularly distressing to the mother because of the family history on her side. It seemed entirely probable that the mother's over-anxious attitude communicated itself to the boy, and did not assist in overcoming the condition. Because of the fact that the family were on relief, and the economic situation was not good, the mother felt that they could not get little extra things for "T" that she thought would do him good.

There was only one other child, a girl of three years (1935). She was a normal healthy child and had given no trouble.

The clinic recommended that "T's" teeth and tonsils be given any needed attention; that he be given a light supper with no heavy foods; and that this be followed by a quiet evening, with a warm bath and a warm drink at bedtime. The clinic was able to assist in obtaining an extra pint of milk a day for the patient's use.

Developments:- During the past two years the clinic has had a number of contacts with "T", mainly through return visits to the Clinic, which have been encouraged. Progress has been satisfactory so far as he has been concerned. Attention has been given his teeth, although his tonsils have not been removed to date. The changes in his evening routine at home have practically eliminated the sleep walking, and the night terrors have disappeared. Some dizziness developed for a time,

but this disappeared following further treatment of his teeth. A note in December, 1936, is to the effect that "T" was then in good health, had no dizzy spells, and had a very occasional spell of sleep walking. He was doing well in school, was in grade four, and was well up in his class.

A feature of the family situation, and one that may lead to further trouble, is the mother's continued worry over the possibility of the children inheriting and transmitting a tendency to mental disorder. Because of this she is over-anxious about the slightest indication of a departure from normal. In the summer of 1936, the younger child, then a girl of four years, bumped her head rather severely. The mother thought that following this her eyes became dull and that she did not look the same. She was brought to the clinic for an examination in the Fall. The examination showed that the child was normal, physically and mentally, and nothing abnormal was noted about the appearance of her eyes. The mother was further re-assured.

If the mother continues her worrying, over-solicitous attitude, there is a grave danger that the children will become over-concerned too, which will lessen their chances of making a satisfactory social and economic adjustment.

Case No. VIII

Male - Over-sensitiveness,
Attempted suicide

This case first came to the clinic in 1933, as a boy of twelve years in grade five. He had attempted to commit suicide by shooting himself with a 22 rifle, the bullet going through the left lung under the heart. He was brought to the clinic after he had recovered from his wound. He may be called "H".

Family History:- The family history was negative, so far as could be found out, except that the patient's maternal grandfather had committed suicide at about fifty-five years, in a fit of despondency. Whether or not this influenced the patient's actions could not be found out definitely. He did know about it. In 1933 the father was fifty-two years old and the mother forty-two years old. Both were healthy, even above the average, and both were of normal intelligence. The father was a farmer.

"H" was the fifth of nine living children, all of whom were reported normally healthy and of normal intelligence. There had been one death, by drowning - a baby boy of ten months. The history of the school progress of the other members of the family showed that all the older ones had completed public school and had taken some high school training.

Personal History:- The birth and developmental history were normal, except that as a baby "H" had been undernourished up to ten months because the parents had had trouble in getting a food to suit him. He was bottle fed. There were the usual childhood diseases, but "H" was never seriously ill. He never had any convulsions.

"H" had been somewhat over-sensitive from babyhood. He had a pleasant personality, mixed readily, and made friends easily. He never had to be whipped for correction. Speaking to him was the only punishment he needed, and even this would bring tears to his eyes. He liked to help around home, and was expecially good with the younger children. As a smaller child he was rather nervous and excitable.

School Situation:- He started school at seven years and appeared to get along normally in all subjects but spelling. While it was not possible to find out definitely the exact cause of the initial trouble in this subject, the information given would indicate that the teacher rather neglected to give him an effective start. He repeated grade two, but otherwise had made a grade a year. He himself liked arithmetic best of his school subjects, and liked to read. He was reported to be a good oral reader.

He was quite interested in sports, and took an active part in the games played by his age-group. His

favorite outdoor sport was baseball. He had shown no apparent shrinking from rough play, despite his sensitiveness to remarks.

The teacher at "H's" school the year of the accident was, apparently, quite sarcastic and would hold different children up to ridicule, especially if they did not do well in their work. "H" felt this more than most of the other children, but there seems no reason to think that he was singled out for special ridicule. On different occasions he had felt very badly over remarks the teacher had made about his errors. As he was poor in spelling, this subject became associated in his mind with ridicule and unpleasantness, and this in turn, undoubtedly, reacted to his disadvantage in learning and reciting, or writing, his spelling. The day before the accident "H's" grade had a spelling test. He had made 45% and was considered to have failed. The teacher called him "little 45", and made him stand up and tell the class the mark he had made. Previous to this particular test the teacher had remarked that "H" would not get 40% on it.

Going home from school that afternoon he had remarked that he felt like shooting himself, and was obviously feeling quite blue and discouraged. He did his usual evening chores at home and went to bed, but it was quite late before he got to sleep.

The following morning he was up at the usual time, 6.30 a.m., and did his share of the before-breakfast chores.

He then asked for his gun, saying he was going down the coulee for a few minutes. He had previously said that he did not want to go to school that day. He did not come in for breakfast and his mother went out to call him. After she had called she saw him coming from the coulee, but instead of coming into the kitchen he went into the basement. He was pale and crying and had shot himself just below the heart. He was taken immediately to the Hospital and made a good recovery.

Following his recovery he went back to school again, and had been going a short time when he came to the Clinic. Little had been said about the accident and "H" appeared to be happy in his return to classes.

Clinic Examinations:- Physical examination showed "H" to be in good physical health. His tonsils were somewhat enlarged - otherwise there was nothing of note.

On a psychometric examination "H" earned an intelligence quotient of 100. He co-operated well and responded quite readily, although he showed some nervousness at first. Test results were closely grouped about the normal chronological age level and did not indicate anything out of the usual.

The situation was discussed with "H", and also with the parents. It was recommended that the situation be gone over with the teacher - which was done.

Developments:- The better understanding of "H" by his parents and his teacher has resulted in a happier

adjustment for him. The shooting incident has been allowed to drop, and the sarcasm and ridicule have been materially reduced. "H" has gone right ahead in his school work, and, as well, has been taking music lessons. The whole picture is a much more hopeful one, and promises a satisfactory social and economic adjustment later on.

This is an outstanding case in which ridicule and sarcasm played a prominent part. There are, however, many other cases in which much unhappiness is caused by thoughtless ridicule. Teachers are far from being free from blame in this regard. Ridicule is so easy to use and it leaves no physical mark. The mental reaction is largely out of sight, but, nevertheless, it is there, and playing a much more important part in the life of the individual than a physical bruise. Ridicule is a method of discipline, and all too often of purely selfish satisfaction for the teacher, that cannot be too strongly condemned.

In considering the whole family situation in regard to this case, it is of interest to note that the oldest boy in the family, also the oldest sibling, came to the clinic late in 1934, suffering from a mild psychosis of a schizophrenic type. He was then twenty-one years old. He was advised to become a patient in a mental hospital for a time, which he did voluntarily. He remained in hospital just over a month, made a good recovery, and was discharged.

To date there has been no further recurrence of his trouble. He is of normal intelligence.

Case No. IX

Female - Schizoid Personality

This case, that of a girl of ten, first came to the attention of the clinic in November, 1932. The problem at that time was stated as - "backward in school; inattentive and untruthful; soils and wets herself at times". In 1933 the chief concern was because of her backwardness and inattention at school. She was then in grade four. There are some rather interesting points about both the family and the personal history, as noted below.

Family History:- There is some reason to believe that a paternal granduncle was insane, otherwise there appears no positive heredity behind the parents on either side of the house. The father, then thirty-nine years old, was in good health and had been so. He was temperate in his habits. He was unemployed then, and had been a real estate agent. He did not take an active, normal interest in the patient, and seemed quite content to let someone else look after her.

The mother was then forty-five years old. She had been admitted to a mental hospital in 1932 suffering from

a psychosis diagnosed as "schizophrenia". She is still in a mental hospital. Previous to her admission to the hospital she was unstable in personality, and had made a poor adjustment, being particularly lacking in the power to make decisions and stay by them. There was, apparently, no suspicion of any intellectual deficiency on either the father's or the mother's side.

Personal History:- The patient's mother had nephritis for two months before the patient was born. At birth the patient, who may be called "P", seemed in a sort of stupor. She remained in a more or less stuporose condition for two or three months after birth. There were no convulsions. She was bottle fed and poorly nourished up to about six months. Her developmental ages were retarded. She was nearly two years old when she began to talk, and was slovenly in speech. Eliminative control was established very late and was not completely established in 1933. After she reached school age she just "could not be bothered" to attend to her personal habits until accidents happened. In any work she was given she was slow and apt to stop unless constantly reminded of what she was to do. In her play she preferred to play with smaller children, and to make as little physical effort as possible. She was not quarrelsome. At her meals she would sit and gaze around, and it would take her half an hour to eat her breakfast. She would

tell lies, even with the contrary evidence before her, and showed no realization of the significance of her untruthfulness. At times her untruthfulness had to do with untrue stories of what some other child had done. She had no chums, and seemed unable to make real friends.

There is only one other child in the family, a boy who was thirteen years old in 1933 and in grade seven. He stood at the head of the class and was recognized as being clever. He was very high-strung and nervous. He has continued to do well in school, and has caused no particular concern to date.

Clinic Examination:- Physical and neurological examination gave essentially negative results. "R" was well developed and nourished. She was unusually tall for her age, being four feet eleven inches in height. For her height she was underweight, weighing 76½ pounds. On tests of co-ordination she gave normal responses, although she was reported as clumsy and slow in her movements habitually. There were some stigmata, such as a very narrow palate and adherent ear lobes.

A psychometric test gave "R" a mental age of nine years and seven months, and an intelligence quotient of 94. Co-operation on the test seemed good and responses were readily given, but there was some lack of spontaneity and interest. Basal mental age was eight years, with one item passed at the twelve year mental level.

A diagnosis of "schizoid personality" was made.

It was recommended that every effort be made to encourage "R" to overcome her bad habits, by explanation and example, and by encouraging her active participation in group and individual school activities, group and competitive sports activities, and similar projects.

Developments:- "R" was placed in a very good orphans' home in the late summer of 1934. This was done for several reasons. There had been no appreciable change in her general condition, and she was showing a tendency to brood a good deal. She continued to play with smaller children, and the children of the school and district talked to her more than seemed proper about her mother, who was still in the mental hospital. At the Home she could be under somewhat more constant supervision and the groups she was with could be controlled to an extent. She was able to attend the school which was attached to the home itself.

She began to show some improvement after the above change was made, although it was slow. In March, 1935, she came to the clinic again for re-examination. Physically she had gained 8½ pounds in weight and four inches in height since November 1933. Her general physical condition was good. A psychometric re-test gave her an intelligence quotient of just 100, whereas before she had earned one of 94. She appeared more open and spontaneous in her personality reactions. In the

Home she was giving no trouble from a behavior standpoint, and had given no trouble soiling and wetting. She continued to prefer smaller girls to play with, but did not try to dominate them. In her work she was inclined still to be absentminded and slow, but had developed more persistence. In school she was in grade five and doing fair work, although she was considered backward, comparatively speaking. She was 11½ years old. While she continued to think about her mother, she did not brood so much about her.

In the last two years the improvement has not been as marked as one would wish. "R" is now 13½ years old, and is practically grown up in a physical sense. Yet she is not making the use of either her physical or her mental powers that she might. She has advanced in her school grades and is now in grade seven, but her work is much poorer than it should be. She is inclined still to be dreamy and pre-occupied, slow in her work and her movements, and lacks the spontaneity and initiativeness of the normal girl of her age.

What will the outcome be? The outlook is not too hopeful. "R" may be able to carry on for a long time in a sheltered environment, but she may not be able to hold her own under the ordinary stresses and strains of life. What part in the picture did her early home life play? It cannot be said, with any degree of definiteness. It would appear that "R" did suffer from

a faulty heritage, but again it is difficult to say just what part that played.

Case No. X

Male - Psychotic

This is the case of a teen age boy who came to the clinic first in November 1935. The original problem was that the patient was troubled with "queer ideas", and some bodily pains, particularly in his stomach. He was attending Technical School in his third year and was reported to be doing average or better work. There was no question of any mental deficiency.

Family History:- No adverse heredity was elicited on either the father's or the mother's side, except that a maternal aunt is at present in a mental hospital - Diagnosis - "Paranoid, paranoic condition - Paraphrenia". In fact, on the mother's side, the history indicated good intellectual and economic capacity with several outstanding ancestors. The mother is of English descent and the father of Danish descent.

The father died from cancer in 1929, at fifty years of age. He was a railway worker and domineering. He had been married previously to marrying the patient's mother. There were two children by the first union, both normal and healthy, and both now grown up and doing well.

The mother was forty-four years old in 1935, and healthy. She had been trained as a stenographer. She had been on relief for several years.

The patient is the second of two children by the second marriage. The other child, a boy of eighteen years in 1935, was reported to be above average in intelligence, although he completed grade eight only. He took up sign painting.

The mother's marital life was rather unhappy. From the time the patient was six years old to the time he was twelve the home was broken up and the children were being looked after by the father. When the father died the mother took the children again.

Personal History:- The patient's birth and early developmental history were normal. He had the usual childhood diseases, but no really serious illness. He was normally friendly with both boys and girls, and enjoyed social affairs. He was interested in sports. He danced a little and liked it. He was interested in model boat building and in radio construction. He was interested in scouting and belonged to both the Boy Scouts and the Sea Scouts.

School History:- The patient began school at six years. He completed public school and was reported to have done very well. When he first came to the clinic he was attending Technical School, in his third year. His teachers at Technical School were included in his abnormal ideas, as

noted below.

Case:- The ideas that the patient had in November 1935 may be illustrated by the following. He thought that all his teachers were returned soldiers, and that they were all conspiring to protect a large treasure trove somewhere in the North. The nature of this trove was not disclosed. He thought for a time that the teachers were trying to get rid of him, because he knew about this treasure. Associated with this idea was one that nearly everyone was taking dope of some sort. He, himself, did not take dope. Other ideas were that he was somehow linked up with a large movement which included the Economic Safety League. He had been a scout guard on the occasion of Baden-Powell's visit to Alberta in the summer of 1935, and he thought that Baden-Powell had said "safety" to him.

The physical health of the patient was good, and he was well developed.

It was recommended that he be kept out of school for a time and given plenty of opportunity for rest, good food, and quietness. He improved quickly and was back to school again in a month. A note on February 3rd. 1936 states that "all abnormal mental symptoms had cleared up".

The patient completed the 1935-36 school year, but failed in four subjects in the final examinations. Mentally abnormal ideas were either absent or were too well covered up to be elicited.

Late in the fall of 1938 ideas similar to those he had had the previous year again became apparent, and became so marked that hospitalization was thought advisable. He was admitted to the Provincial Mental Hospital late in October, 1938. In hospital his ideas persisted for some time, with some confusion apparent. He is still in hospital but his condition is slowly clearing up. A diagnosis of "schizophrenia" was made.

It is difficult to say to what extent this boy's present condition is linked up with his home life, but it must have been affected by it. Early discord, followed by a period away from the mother, as is followed by a period with her but under some economic stress, no doubt played a part. Then there would be the question of an economic adjustment looming up, following the school course. So far as could be found out, there were no particular stresses within the school itself.

The prognosis is none too good. With the history to date one may expect other attacks, especially if conditions are such as to bring additional stresses to bear. Sterilization is recommended in this case by the hospital medical staff from the standpoint of the mental disorder. Also the patient, as the bread-winner of a family, might be prevented by his mental disorder from providing for his family for relatively long periods of time, which periods are likely to lengthen as attacks recur.

CHAPTER IV

CONCLUSIONS AND SUGGESTIONS

There is sufficient evidence to show that our Mental Hygiene program in Alberta is proving beneficial to many. It is just as evident that there are many more who would benefit from the help that they might receive from the clinic services, were these available. Those who work with the clinics fully realize that the services that are offered at present are far from the best that could be offered. At the same time it is felt that the beginning made is a reasonably good one, and one that may serve as the basis for further extension of services. The present clinic personnel is too small for the best results, and at several clinic centers the possible contacts are too infrequent. In the present organization of the clinics the physician in charge has to make his clinic duties a lesser part of his whole work, thus preventing the study of cases which he may feel to be desirable. This could be remedied by assigning a psychiatrist to the clinics on a full time basis, or by increasing the staff of physicians at the mental institutions so that one or two of the doctors would be available for Mental Hygiene clinic work. There is excellent material available at present were the pressure of institutional work lessened. Alberta has been fortunate indeed in the caliber of the men who have been

directing the mental health program for the Province.

There is need for additional psychiatric social workers to make the clinic work more effective. In many instances outside investigational, and follow-up work would pay dividends, but this is seldom possible at present. With the clinics already established more outside contact work would bring the clinic services to more people. Then with an increase in personnel it would be possible to open clinics at other centers, again widening the field of service. But all of this would cost money - which is hard to get.

Another phase of the mental health program which might be widened is that of educating the people in mental health principles. An active program throughout the Province, working with, and through, welfare and service organizations already in existence would be beneficial. Talks could be given, problems could be discussed, and study could be directed if a personnel were available to do the work. A start along these lines has been made but much remains to be done.

Extra-institutional work with ex-mental hospital patients is another avenue along which the mental health services could be expended. There is no doubt that much more could be done than is being done to assist patients leaving hospital to re-establish themselves, and to help them to maintain a satisfactory adjustment in the

community in which they live. It is a fact that a number of patients who leave a mental hospital recovered, or partially recovered, go out into the environment which helped to aggravate the initial mentally diseased condition, and there they are expected to carry on without further help. An investigation of the environmental conditions, and a quiet chat with those with whom the patient will come in constant contact could be of considerable value as an aid to re-adjustment. Also, the ex-patient would have an understanding friend to turn to should the need arise.

Mental health and physical health are so closely bound together that it is impossible to separate them. Hence the value of co-ordinated efforts in the two sections of the one great field. It would not be difficult to set up a system whereby there could be kept a worth-while record of each individual's mental and physical health and adjustment, and his academic progress through the most formative years of his life. This could be used as a basis on which to direct later life activities. How much happier and more efficient J. and B. of case II would have been could they have been more wisely directed earlier in life. The mental health clinics have enough cases of mal-adjustment and discontent to deal with to indicate the magnitude of the problem, and to indicate, as well, how much depends on the acquiring of the proper

attitude towards a type of work suitable for the individual concerned.

The work done under the Wyandotte Board is very important and more investigation work could be carried out in regard to cases operated on and their subsequent adjustment. This could be done very naturally through the Mental Hygiene clinics. Work of this kind will be more necessary now than previously, with the increased power given the Board under the recent amendments to the "Sexual Sterilization Act".

The cases considered in Chapter III illustrate some of the problems that are to be solved in the lives of those in any community. The factors that help to create these problems are many and various. One factor that does play a big part is the home life of the individual. Those who have had the advantages of a stable family background and home life are more likely to meet life successfully than those who have not had these advantages. Time and again it is found that trouble starts when the home is disrupted. The breaking up of the home, or serious disharmony in it has the effect of seriously shaking the childs feeling of security. When the child no longer feel that he "belongs" in a stable, and to him a permanent, unit of society he is likely to do things that we consider anti-social. He may develop a "don't care" attitude and be ready for any

escapade that presents itself. Or his misdeed may have as their basis an attempt to persuade himself that he is big enough and strong enough to stand up against others. Particularly with those of limited intelligence the anti-social reactions may be due in part to lack of ability to understand the seriousness of the trouble they may get into. This holds true to a degree with all juveniles of course. With security gone there is often a lessening of self-confidence and self-respect which makes it easier for the juvenile to drift into bad company. Once associations of an undesirable kind are formed they are hard to break, very often.

The whole range of juvenile cases may be divided into two groups on the basis of comparative intelligence - (1) those that are manifestly mentally deficient; and (2) those that are of normal or superior intelligence. With the first group the fact that intelligence is limited must be kept in mind, and must definitely limit the scope of the possibilities open. Additional intelligence cannot be supplied, additional capacity for judgment cannot be given, but additional training in suitable occupations and work can be given, and additional training for the formation of good personal and social habits. With the best of efforts and the best of intentions the members of this group will continue to require help, supervision, and direction in grappling with many situations in life.

Many of them will become wholly, or in part, a State charge and responsibility. Many will fall into evil ways because they have not the judgment and power of inhibition to avoid these. Many will be used as tools by more intelligent human beings. And many will find a niche in life where they can carry on, happy in what they are able to do.

The situation with regard to the second group is different. Here are children of normal, or better, intelligence, who have become mal-adjusted. The human material is of better quality and the problem is to insure that it will be put to better use. Many in this group can be re-directed into courses that will be beneficial to themselves and to the State. Some will continue to show mal-adjustment and will find themselves finally in a mental hospital. Others will manage to get along - full of complaints and aches and pains. Others again will prey upon society using their intelligence to accumulate ill-gotten gains. What the end and product will be in each case is an open question in many instances. But many can be helped to adjust in a way that is socially acceptable, and this is the fact that encourages those who work with such agencies as Mental Hygiene Clinics.

Lastly, may a plea be made for the good home - the one unit in our society that can combine security, good training, proper habits, emotional balance, and all of those other factors that go to make men and women in

the best sense of these terms, - for the people of the nation and the world.

APPENDIX A.

Tables XIV and XV show in condensed form the work done by the Eugenics Board for Alberta to the end of 1936, on the basis of the number of cases passed, and the number of operations done. Table XVI gives an analysis of the cases operated on on the basis of the mental disability suffered. Table XVI shows that of those operated on nearly two-thirds were mentally deficient with or without other complicating factors. In almost half of the cases operated on mental deficiency was without other complicating factor such as psychosis or epilepsy.

TABLE XIV

TOTAL NUMBER OF CASES REGISTERED TO THE EUGENICS BOARD OF ALBERTA AND PASSED BY THEM BY YEARS TO DECEMBER 31 - 1936

Year	Male Cases	Female Cases	Total Cases
1929	1	3	4
1930	6	36	42
1931	25	63	88
1932	20	43	63
1933	35	56	91
1934	132	82	214
1935	125	97	222
1936	103	88	191
Totals	445	468	913

TABLE IV

TOTAL NUMBER OF [illegible]
[illegible]
[illegible]

Year	Operations on Males	Operations on Females	Total Operations
1929	1	2	3
1930	6	30	36
1931	13	51	64
1932	15	34	49
1933	13	41	54
1934	46	59	105
1935	33	51	84
1936	35	42	77
Totals	162	313	475

TABLE XVI

AN ANALYSIS OF THE 475 CASES OF MATERNAL,
ADMITTED BY THE PSYCHIATRIC BOARD FOR AUSTRALIA
TO DECEMBER 31, 1953

Total Number of Cases Operated on..... 475

Total Male Cases.....162 (34.1%)

Total Female Cases.....313 (65.9%)

475

Psychotic Group:	Number	Percent of Group	Percent of Total
Schizophrenia	79	56.1	16.7
Manic Depressive	35	24.8	7.4
Epileptic	14	9.9	2.9
Organic Types & G.P.I.	13	9.2	2.7
TOTALS	141	100%	29.7
Defective Group:-			
Mental Defectives	228	75.2	48.0
Mental Defectives with Psychosis	52	17.2	10.9
Mental Defectives with Epilepsy	23	7.6	4.8
TOTALS	303	100%	63.7
Other Types and Undiagnosed Psychosis:	31	100	6.5
GRAND TOTALS	475	100	100

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